



Changes to Medication Information 2016

Student's Name: _____

Medication: (During School Hours)

Does your child require daily medication? YES NO

If YES:

Name of Medication/s	Dosage (amount)	Time/s to be taken	How is it to be taken? (eg orally/topical/injection)	Dates
				Start date: / / End Date: / / <input type="checkbox"/> Ongoing medication
				Start date: / / End Date: / / <input type="checkbox"/> Ongoing medication
				Start date: / / End Date: / / <input type="checkbox"/> Ongoing medication
				Start date: / / End Date: / / <input type="checkbox"/> Ongoing medication

Medication Storage

Please advise if there are specific storage instructions for the medication.

School Medication Instructions

All medication must be clearly marked. Preferably in a pre-packaged pharmacy webster pack with a weeks supply as well as:

- Student's name clearly marked
- Dosage amount to be administered
- Name of medication
- Time the medication is to be administered
- Is in original package
- The pharmacy label matches the information included in this form

PLEASE TURN OVER

Medication: (After School Hours)

In an emergency situation we need to be aware of medication your child may be taking after school hours:

Name of Medication/s	Dosage (amount)	Time/s to be taken	How is it to be taken? (eg orally/topical/injection)	Dates
				Start date: / / End Date: / / <input type="checkbox"/> Ongoing medication
				Start date: / / End Date: / / <input type="checkbox"/> Ongoing medication
				Start date: / / End Date: / / <input type="checkbox"/> Ongoing medication
				Start date: / / End Date: / / <input type="checkbox"/> Ongoing medication

Monitoring effects of Medication

Please note: School staff *do not* monitor the effects of medication and will seek emergency medical assistance if concerned about a student's behaviour following medication.

Privacy Statement

The school collects personal information so as the school can plan and support the health care needs of the student. Without the provision of this information the quality of the health support provided may be affected. The information may be disclosed to relevant school staff and appropriate medical personnel, including those engaged in providing health support as well as emergency personnel, where appropriate, or where authorised or required by another law. You are able to request access to the personal information that we hold about you/your child and to request that it be corrected. Please contact the school directly or FOI Unit on 96372670.

<u>Authorisation For Medication Administered At School</u>

Name of Medical/health practitioner:
Professional Role:
Signature: Date:
Contact details:

Parent/Carer Signature: _____

Parent/Carer Name: _____ Date: ____/____/____

Please Note: All forms must be completed and signed whether the information required applies to your child or not.

BVS VALUES: TEAMWORK RESPECT FUN DIGNITY SUPPORT